MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 11, 2003
10:20 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Disease management and care coordination in traditional Medicare
-- Nancy Ray, Joan Sokolovsky

MS. RAY: Good morning. Joan and I are here to provide you a brief overview about disease management, why it's being considered in traditional Medicare. We will also talk with you about our work plan, how we propose to look at this issue.

Our goal is that our June 2004 report will include a discussion of the use of disease management in traditional Medicare.

As outlined in your mailing materials, the objectives of disease management are varied and changing and may include coordinating care across providers, helping patients identify and manage conditions, and encouraging adherence to evidence-based treatment guidelines. The strategies used by the numerous providers are also varied and evolving, ranging from programs being disease-focused versus beneficiary-focused, whether patients are opting in versus opting out, the extent to which care coordination services are emphasized versus self-care management services. Use of nurse coordinators varies from program to program, as well as the involvement of physicians.

The conditions that these programs often focus on are high cost conditions, and they include diabetes, CHF, COPD, asthma, as well as end stage renal disease.

In your mailing materials, we summarize why disease management is being considered in traditional Medicare. Some of these reasons include many researchers have shown that a small proportion of fee-for-service beneficiaries account for a disproportionate share of Medicare expenditures. Anne's presentation referred to 5 percent of beneficiaries associated with 47 percent of spending.

These beneficiaries often suffer from one or more chronic illnesses and are often repeatedly hospitalized. I guess the example I'd like the point out is, of course, patients with end stage renal disease. Other patients who fall into this group, as well, are patients with CHF and diabetes.

There are also other groups of patients who also incur high cost for a period of time and may also benefit from some type of intervention. One example here being patients at the end of life.

We talk about, in your mailing materials, why disease management is being considered for patients with chronic kidney disease. Here the thought is that early identification and referral to physician care, not one or three months before dialysis onset but a year before dialysis onset, will enable patients to become better educated about their condition, about their treatment alternatives. It could increase -- because they're being referred to care way ahead of time, it will allow the selection of the right vascular access. AV fistulas, they'll have a chance to mature. It may be result in improved clinical

status for the patients because you're starting to manage their comorbidities earlier like malnutrition and anemia as well as their cardiovascular comorbidities.

Some researchers contend that the outcomes of dialysis patients will be improved through such interventions, earlier identification and referral to physician care, and will ultimately lower morbidity and improve their survival once they do become end stage.

As Joan will discuss, this is one of the issues we are planning on drilling down on when we take a look at this issue. By reviewing the literature, looking at the studies that have been published on this topic, the methods that have been used, how they measure outcomes, and the time frame that they're measuring outcomes, whether it's one year after becoming end stage or five years after dialysis.

The other reason why disease management is also being considered in traditional Medicare, and I'd like to say it's not just traditional Medicare but, of course, other payers as well, is there is little focus on prevention and education. The payment systems don't relate to each other very well. And generally care is not patient-centric.

CMS is implementing a series of demonstrations testing disease management and the ability of these interventions to improve quality of care and control program costs in different patient populations, including folks with chronic heart failure, diabetes, and ESRD. I guess I'd like to highlight the new ESRD disease management solicitation that just came out in June.

It's being offered in both the fee-for-service world as well as the capitated world. I'd like to highlight the four design features of it. Yes, it's testing disease management. In the fee-for-service world it is also testing a broader payment bundle. In the fee-for-service world, it is testing holding providers partially at risk. And then finally, it's testing a quality incentive withhold. For both fee-for-service and capitated providers 5 percent of payment will be withheld and providers can get back that 5 percent if they improve care within their facility, as well as meet, well exceed national thresholds.

Those quality indicators are for dialysis adequacy, anemia, malnutrition status, bone disease, and vascular access.

So at this point, Joan will take over the presentation and talk about our work plan.

DR. SOKOLOVSKY: As nancy has told you, we plan to conduct research this year on issues related to the development of disease management and care coordination services within traditional Medicare. Some of the issues that we've identified so far for particular work include the targeting of program participants, payment mechanisms, including the role of risk in payment mechanisms, and a number of implementation issues including how to measure success, outcomes of disease management programs, and also the availability and timeliness of data.

Our work will include a combination of data analysis, evaluation of the literature, and interviews with stakeholders.

We have identified a number of potential populations that could benefit from care coordination. You see the list up there,

and some of this has already been discussed. Beneficiaries with specific high cost conditions, beneficiaries with multiple chronic conditions, high cost beneficiaries, dual eligibles or beneficiaries needing end of life care.

One of the issues for us to analyze this year are the advantages and disadvantages of targeting Medicare programs to different populations. We also need to consider issues around implementation of population-based disease management programs within traditional Medicare.

As a first step in dealing with this targeting issue, we will construct a database using data from the 5 percent claims filed for a six-year period from 1996 to 2002 and hopefully be able to add data as more data becomes available.

We think that there will be many possible ways that we can use this database once it's constructed but some of the possible things would be to allow us to look at the use of services for each of these different populations, assess the prevalence of comorbid conditions amongst the 5 percent sample, identify characteristics of beneficiaries with very high cost expenditures.

As data becomes available, we would also like to examine the Medicare and Medicaid claims of a sample of dual eligibles. This will provide us with a more complete picture of total Medicare expenditures of a set of high cost beneficiaries. In particular it would give us the prescription drug utilization and expenditures of these beneficiaries.

Expansion of disease management programs within traditional Medicare would require decisions on a whole set of payment issues. For example, who is paid, how should the payment be set, and what are the role of non-covered services, for example transportation, which is a very important issue among care coordination services.

We plan to examine the implications of different payment options. We also plan to look at the issue of risk. Currently, in some of the private programs we've looked at, performance fees by disease management organizations tend to be at risk but Medicare demonstrations that Nancy spoke about a little bit earlier are testing many different models of risk sharing and we're going to be talking to people at CMS and getting a better idea of the different strategies that are out there.

Finally, there are a wide range of implementation and data issues. Programs require timely and accurate information to identify populations, monitor their conditions, track their use and cost of services, and measure their quality of care. Most available data sources are limited. For example, and this is something that many disease management organizations have pointed out, very few programs have access to lab results in real time, and yet all agree that this would be a really critical source of information for monitoring beneficiary conditions.

Drug data is both timely and accurate and an important indicator of adherence to clinical guidelines and patient compliance. But just from looking at drug data, it is impossible to know what conditions beneficiaries are being treated for.

Currently, in fact, most programs focus most heavily on

self-reports by beneficiaries which are again a very important source of data but limited. There are number of programs out there trying to increase the amount of available possible information that can be received from self-reports.

Other implementation issues include the number of programs that could be available in an area. We have heard from physicians already that they are concerned about receiving frequent and possibly conflicting messages about their patients from different organizations.

Finally if programs are available in a particular area for multiple chronic conditions, what rules would be used to determine in which program beneficiaries with multiple conditions should be enrolled? The way that we understand it currently, disease organizations target people on the basis of a particular chronic condition, but then they are responsible for treating the whole patient with all of their comorbid conditions. On that basis then you would think there could be perhaps a hierarchy of conditions determining which beneficiary would be enrolled in which particular program.

And also, there is the question of the period of time for which a beneficiary would be enrolled.

Our goal is to address these issues for a chapter in the June 2004 report and we'd very much like to have your comments and also some discussion of other issues we perhaps should be including.

MR. HACKBARTH: So in the last discussion, one of the key points was lamenting the fact that our traditional provider-centric approach to thinking about quality misses the fact that patients move across the different types and it doesn't really capture the patient experience of quality.

The appeal of this, of course, disease management is that it cuts across that and it's an effort to try to look at quality on a different axis.

DR. ROWE: I think this is an excellent set of questions to address. I'm very interested in this issue. I'd like to make a of couple points about it.

First of all, I think that there are basically five elements to disease management programs. It's identifying the patients, some evidence-based intervention, patient education and self-management, a measurement or an evaluation or course adjustment of where we are, and then communication between the providers and the patients and the disease management people. I think it would be helpful to organize this or describe that in the beginning.

The single most important piece, by far, without any question, is the identification of the people that you put in disease management. The disease management protocols, whether it's from the American Diabetes Association or the American College of Cardiology or whoever, are commodities at this point. They are off-the-shelf. Sure, you can implement them well or badly but it's all about finding people who are at risk.

It's not necessarily the high cost beneficiaries which is a subpopulation you identified. It's the high risk beneficiaries. What you need to do is take the database and interrogate it in such a way to do some predictive modeling, to say who is going to

be a high cost beneficiary in the future, not who necessarily is a high cost beneficiary now.

So there are certain characteristics of the individual such as their cholesterol and their hypertension and whatever that puts them at risk as a diabetic, not somebody who's already had the problem. I think the focus should be on high risk people.

And this is not worth doing for Medicare unless the answer to the question on the bottom of age 18 of your chapter is no. You have to start there. If the question is is every Medicare beneficiary in a region going to be eligible for these? If the answer to that question is yes, then we should stop because this is going to tank Medicare. This is only valuable, clinically and financially, if you target the right population. Otherwise, you are doing things to people that have no value and are costly. And I just can't emphasize this enough.

So the benefit that large health plans have in doing this is that we have databases that includes pharmacy data and laboratory results, yada, yada, yada, and we are able to interrogate these databases.

So when I hire a disease management company to do a diabetes or chronic heart failure or whatever, they'd say okay, we want to every diabetic. Well, at Aetna we have one million diabetics. We say no. And we interrogate the database and we identified something like 225,000 diabetics. And we said we think these are the ones.

It's very, very, very important.

I think we need to emphasize that because otherwise Congress or somebody is going to get pressured into making it available to everyone, in which that's got to be a stop, don't go forward decision.

Secondly, I think that it would be great if we could start to pressure the disease management entities to demonstrate sustained benefit in outcomes rather than in processes of care. Rather than just hospitalization rates, medication rates, et cetera, patient satisfaction measures are generally improved in these cases and programs, but some functional improvements or something. Let's build in outcomes other than processes of care that really are meaningful to the quality of care. And I think the third question has to do with the very, very important intersection of the patient and the physician. Who is doing the disease management? Is Medicare hiring a company to go do the disease management? Or is Medicare going to pay the doctor more if the doctor can demonstrate that he or she has got the patient on the ADA disease management program?

Now generally in health plans, we have a couple of demonstrations, one in San Antonio and one in L.A., where we are paying the physician groups to do it which I think is the preferred route. The problem is that a group of cardiologists might have 25 patients to put in the program, whereas nationally I can contract for 30,000 chronic heart failure patients so I get a better price. So it's hard for the physicians in the group of cardiologists to actually do it at something that would be cost-effective. So there are considerations like that.

But what you don't want to do is you don't want to set up an

alternative pathway of care. Joan, you said -- and it was a slip but it's it's an important slip. You said that the disease management programs are taking care of the patient. They are not taking care of the patient, the doctor is taking care of the patient.

The disease management programs are an adjunct to the physician. They are a supplement. They are a nurse calling the patient, making sure you're on the medicines, have you gained any weight? Did you make your appointment? Can I help you, et cetera?

But Medicare can't get caught into even the language of developing an alternative pathway of care for its patients.

So it's really important, I think, to understand that we need to align this in such a way that it is done with the approval and the consent and the involvement of the doctor. And if you do it that way, then it works. If you don't, it's just a wasted expenditure in many ways.

So those are just three points. Specificity with respect to who is included, very disciplined, something clear about outcomes rather than processes, and some clear alignment of the relationship with the doctor would be things I would emphasize. Thank you.

MR. FEEZOR: It's always good to follow the new Aetna. Actually, a couple of my points are right write off of Jack's.

First off, if we do focus on the ability to identify that high risk individual, we probably need to have some discussions in terms of confidentiality and the tussle that we will have there.

Secondly, Joan and Nancy, I think as you do a study of the literature, I think identifying those programs that seem to have a greater consumer engagement in the area of self-management, and some things that might contribute to that, would be very helpful as far as what we might provide on that.

And then the third, I guess, is a question I would ask for Mark or Glenn. Is the Medicare RX so far down the path that perhaps us talking about how valuable that data segment is, in terms of a really effective disease management, in other wards the ability to integrate. First off, that's presuming that there will be some sort of Medicare RX, and that may not be a safe assumption. But that we might talk about the importance and the use of that data in being able to link up, as Joe said, so that we get back to the individual patient. I think some negative would be very timely on that.

DR. MILLER: I'm really glad you asked that question. When we do the risk assessment this afternoon, we're going to be talking about the role of drug data in issues like that, and we can have that conversation, and Joe has already begun to give us comments on that. So that will be right on point.

MR. DeBUSK: Most of what I had to say, and then way beyond it, Jack covered. But I noticed, Nancy and Joan, in the back of the chapter here you referred to clinical guidelines are another important source of information and the basis for most care coordination interventions. All disease management programs rely upon clinical guidelines developed by medical specialty

societies.

I guess we could substitute protocols for clinical guidelines here. But I think what would be really interesting in your research, if it's available, is to look at what affect protocols have on outcomes, especially with the diabetic patients. There are some 50 million diabetic patients today and the cost, as we know around this table, is just unreal. But diabetes is a very, very costly disease. Although there's a lot of protocols out there, I sometimes wonder how many of them are used. So there's a wide variation here, but if there's any patterns there as to the efficacy, it would be very interesting.

MS. ROSENBLATT: I want to say I also agree with Jack on the question of who is included. I think he made a very appropriate remark and I think that's a big issue.

You touched on this, on the subject of how do you measure this thing. That's a question that I'm really interested in and I think you talk about it's really hard to measure it because it's hard to get a control group. So I'd like to see the final chapter dealing with disease management spending a lot of time dealing with the issue of how hard it is to measure this.

DR. REISCHAUER: I thought this was very interesting presentation. I learned a whole lot from it.

The way it was structured, though, I think you sort of went to the second level without stressing sort of the first level. Like on why consider this for Medicare? There are really three answers. One, it could be good for the beneficiary. Two, it could be good for the taxpayer. And three, BIPA requires it. And then these other things really fit into one of those or the other.

But what I thought was lacking here is some discussion, which admittedly I think could come in later versions of this, which is the obstacles, the hurdles to this. We have to ask ourselves if this could be good for either beneficiaries or the bottom line why has so little of it been done over the course of history? Jack pointed out one thing, which it's really very hard to do, to identify the right people and develop the right procedures here.

But also, there are some likely resistance on the part of beneficiaries because this might be more intervention, more control, lack of flexibility that they had. There's clearly likely to be some resistance from providers to yet another layer of something intervening in their activity. We do have a Lone Ranger mentality to the medical profession often. It's okay to have Tonto, but you don't want the general at the fort overseeing you.

And we have a payment system that doesn't encourage this. I think there's a real possibility that you could run demonstrations like this and you could find that they're good in one of these senses. And yet, you then have a very hard time rolling this out across the nation. We should just raise that as a possibility.

I think there's also a very good chance that if these are beneficial to the participant, they will end up, over the lifetime of beneficiaries, costing more. That's not to say they

shouldn't be done if they're providing better health care. But reading some of the recent literature it seems like the big problem is under-provision of services as opposed to mis-provision. This is a way of getting appropriate care maybe provided to more people earlier. And if you discount this correctly and add extended lifespans and things like that, it might add to the bottom line.

MS. RAPHAEL: I wanted to follow up on the point that Bob made because I thought that we had to speak a little bit about the barriers here.

We actually have been doing a major demonstration from one of the large health plans for their disease management program where the telephone calls were not successful in altering the behavior of the people in the disease management program who still were having a lot of physician visits and ER visits, et cetera.

So the plan contracted with us to go into the homes of these particular members to see if we could influence their behavior. It was very illuminating. The people that we dealt with were very resistant to being in this disease management program. They wanted to be able to sign something that got them off the hook as quickly as possible. And their first question is am I required to do this because I don't want any of it.

So I was very surprised with that because that was kind of counter to the conventional wisdom that this really promotes education and self-management and better outcomes and therefore would be received favorably by members. So I think we just need to be aware of that.

And I just had another question about scalability because we don't want another group of boutique programs here that you really can't bring into the mainstream and that aren't scalable. I think this is something we need to take a look at.

DR. ROWE: I'd like to comment on Carol's experience or that plan's experience. I don't know what that plan was and how it was done, but I believe that the experience in the field suggests that that's the kind of outcome you get when the health plan goes to the member and says we're going to enroll you in a disease management program.

But if the health plan goes to the doctor and says we've looked at your patient population who are insured by us and we have identified these patients who we think are at risk. And you're busy. We're going to hire under a nurse to call them and check with them and check with you and let you know if they run out of medicines and get the pharmacy to deliver things, et cetera, et cetera, et cetera. If you are willing to have this patient in this disease management program, we what you, the doctor, to enroll the patient.

And if you do it that way you get a much greater, I believe, beneficial effect. I don't know how you got to where you were with that case, but this is my point about the alignment with the physician. It's all about that doctor. You know, I'm from the government and I'm here to help you, for somebody in the Medicare program, is just not going to work.

MR. HACKBARTH: Good point. Nick, and then we're going to

have to move to conclusion.

DR. WOLTER: I'll try to be brief. I just want to comment on the measures of quality and maybe take a slightly different slant on it than Jack did. This comment would be equally, if not more applicable to our previous discussion on quality.

But I think a lot of the people in the quality movement are looking at processes of care in the sense of either therapeutic or clinical appropriateness of the intervention that's done. Most of these are not measured by administrative systems. It would be the time from arriving in the emergency room for getting an antibiotic for community-acquired pneumonia. It be the time to cath from arriving with acute MI. It would be whether the antibiotic was delivered within one hour of surgery rather than two or three hours before. And must administrative systems don't pick up that kind of data.

I think as we look at our measurement models, both in the quality work we're doing and in this chronic disease management work, it's going to be important to remember that at the end of the day it's those measures, because they're based on evidence-based medicine, there's prior knowledge that doing those things create a better outcome. So it's not specifically the measure of the outcome, it's a measure of the interventions that are known to create the better outcome.

When those things start to be measured they create changes in behavior amongst physicians, amongst delivery systems. I think it's really what's going to drive a lot of the improvement in quality and health care. It's really going to drive a lot of the improvements in chronic disease management. But these are not easy to measure right now and they're not well measured on the administrative systems. But I think we should keep our eye on that aspect of the measurement system in the work that we do.

MR. HACKBARTH: Mark is going to sum up what he's heard here.

DR. MILLER: Because there are a couple of things that I thought were particularly interesting here. I wanted to say to Jack, and I can say it to him offline, as well, his emphasis is well taken. But I just wanted him to know that several of the things that he mentioned, we've had discussions about on point in the staff and are very sensitive to. The notion of a typology and even beyond the typology that he talked about is also distinguishing between things like disease management, case management, and care coordination, because that whole spectrum needs illumination.

His point on identifying the patient, we have had several conversations on this and are well aware of the critical feature there. And the notion of what is the measure for them, because I think the literature does say you can get patient satisfaction to change and even processes to change and the literature is much less clear on the outcome. So his point about pressure on sustained outcome is really well taken.

The physician angle is interesting. In my experience, this question has gone both ways. Physicians who have said don't involve me, and just traffic with the patient and leave me out of it. And then other experiences where the physician has said if

I'm not central to this it won't work. And I think probably the trend is headed in that direction, but that will be an interesting question that we will continue to try and sort through.

To Alice's point, we're very interested in that issue and we hope that you can identify some people that we can talk to out in the actuaries' world about those kinds of things or some other people that we can talk to. We have our ideas but we are very interested in that.

I also thought the exchange on the beneficiary resistance was really interesting. Because my experience up to this point has been people are yahoo, I really want to be part of this. And I think this point is really well taken and this may be the key back to the physician issue, as Jack said. And we'll pay particular attention to that. Because coming up to this meeting, I've been under the impression that people are just all happy to be involved in this.

DR. WAKEFIELD: Can I comment on that last point? You might be able to generalize exactly from what was stated on that point, and actually we had a sidebar conversation here. I'd say that might also play differently, depending on access and utilization of services, that is the responsivity to this set of new services.

Generally speaking, people in rural areas are happy to see the horse that Tonto road in on, if nothing else. So I think the willingness to open the door and invite the assistance might be quite different.

MR. HACKBARTH: We will now have a brief public comment period.

Okay it's over. Did you have -- sorry, go ahead.